GENERAL INFORMATION

Patient Information

Name: _____ Date: _____

Mailing Address: _____ City: _____

State: _____ Zip: _____

Home Phone #: _____ Work #: _____ Cell #: _____

Sex: Male Female Marital Status: ☐ S ☐ M ☐ D ☐ W Age: _____

Date of Birth: _____ Social Security #: _____

Emergency Contact Name: _____ Emergency Phone #: _____

Are you currently receiving Home Health (HH) for any reason? ☐ Yes ☐ No

(If answer is NO and HH services are being provided, patient is responsible for any services not covered by ins.)

How did you hear about us? (*Please check all that apply*) ☐ Phone Book ☐ Doctor

☐ Friend ☐ Billboard(*location*): _____ or

☐ Other(*description*): _____

Employer Information

Employer Name: _____ Employer Phone #: _____

Occupation: _____ Work Status: _____

Injury Questions

Date of Injury: _____ Date of Surgery: _____

How were you injured?: _____

Is this injury:

Employment Related? ☐ Yes ☐ No Injury from an Auto Accident?: ☐ Yes ☐ No

Is an Attorney involved?: ☐ Yes ☐ No Claim or Case #: _____

If YES, please provide Attorney Name: _____

Attorney's Address and Phone #: _____

_____

Responsible Party

Guarantor for Account: _____ Social Security #: _____

Guarantor's Address: _____ City: _____

State: _____ Zip: _____

Guarantor Phone #: _____ Alternate Phone #: _____

Insurance Information *(mark SAME if information was previously given)*

Please give your insurance cards and ID to the front desk to make copies.

Primary Insurance: _____ Insured's Name: _____

Insured's DOB: _____ Insured's Social Security #: _____

Secondary Insurance: _____ Insured's Name: _____

Insured's DOB: _____ Insured's Social Security #: _____

I certify this information is true and correct to the best of my knowledge. I authorize payment of benefits to Precision Physical Therapy, PLLC. I acknowledge that I am ultimately responsible for payment of services received.

Signature of Patient or Guarantor if Patient is a Minor **Date**